

**§ 409.43 Plan of care requirements.**

(a) *Contents.* The plan of care must contain those items listed in § 484.18(a) of this chapter that specify the standards relating to a plan of care that an HHA must meet in order to participate in the Medicare program.

(b) *Physician's orders.* The physician's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished. Orders for services to be provided "as needed" or "PRN" must be accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered, the upper limit of the range is considered the specific frequency.

(c) *Physician signature.* The plan of care must be signed and dated by a physician who meets the certification and recertification requirements of § 424.22 of this chapter. The plan of care must be signed by the physician before the bill for services is submitted. Any changes in the plan must be signed and dated by the physician.

(d) *Oral (verbal) orders.* If any services are provided based on a physician's oral orders, the orders must be put in writing and be signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in § 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Oral orders may only be accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The oral orders must also be countersigned and dated by the physician before the HHA bills for the care.

(e) *Frequency of review.* The plan of care must be reviewed by the physician (as specified in § 409.42(b)) in consultation with agency professional personnel at least every 62 days. Each review

of a beneficiary's plan of care must contain the signature of the physician who reviewed it and the date of review.

(f) *Termination of the plan of care.* The plan of care is considered to be terminated if the beneficiary does not receive at least one covered skilled nursing, physical therapy, speech-language pathology services, or occupational therapy visit in a 62-day period unless the physician documents that the interval without such care is appropriate to the treatment of the beneficiary's illness or injury.

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**§ 409.44 Skilled services requirements.**

(a) *General.* The intermediary's decision on whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual beneficiary. A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care.

(b) *Skilled nursing care.* (1) Skilled nursing care consists of those services that must, under State law, be performed by a registered nurse, or practical (vocational) nurse, as defined in § 484.4 of this chapter, and meet the criteria for skilled nursing services specified in § 409.32. See § 409.33(a) and (b) for a description of skilled nursing services and examples of them.

(i) In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice.

(ii) If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service.

(iii) The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary's family or friends does not negate the skilled aspect of the service when performed by the nurse.